(b) To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31, 2002. If a facility's plan for wage and benefit distribution is effective for its employees after July 1, 2002, the portion of the rate adjustments are effective the same date as its plan.

(3) A hospital-attached facility may include costs in its distribution plan for wages and benefits and associated costs of employees in that organization's shared services departments, provided that the facility and the hospital share common ownership and adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months before July 1, 2002. If a hospital-attached facility meets these qualifications, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of the funds is shown as being attributable to employee hours worked in the facility or employee hours worked in the hospital.

D. Notwithstanding Sections 1.020 and 18.020, upon the request of a facility, the Department may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under item A, Section 11.051, items B and C, and item B of this Section. Until the rate is finalized, the Department will require any amounts collected, which must be used as provided in this item, to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance. The Department shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final rate are repaid to the private-pay residents with interest.

E. Each facility paid pursuant to Sections 1.000 through 22.000 receives an increase in each case mix payment rate of $1.25, which is added following the determination of the payment rate for the facility. This increase is not subject to any annual percentage increase.

SECTION 11.060 **Total operating cost payment rate.** Through June 30, 1999, the nursing facility's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care-related payment rate determined in Section 11.020 and the adjusted other operating cost payment rate determined in Section 11.040.

SECTION 11.070 **Salary adjustment per diem.** Effective July 1, 1998, the Department shall make available the appropriate salary adjustment per diem calculated in item A through D to the total operating cost payment rate of each nursing facility subject to payment under this attachment, including Section 22.000. The salary adjustment per diem for each nursing facility must be determined as follows:

A. For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the Department shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

B. For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under item A.

C. A nursing facility may apply for the salary adjustment per diem calculated under items A and B. The application must be made to the Department and contain a plan by which the facility will distribute the salary adjustment to employees of the facility. In order to apply for a salary adjustment, a facility reimbursed pursuant to Section 22.000 must report the information required by items A or B in the application, in the manner specified by the Department. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may constitute the plan for the salary distribution. The Department will review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem is effective the same date as its plan.

D. Additional costs incurred by facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998 cost report.

SECTION 12.000 DETERMINATION OF INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES

SECTION 12.010 **Conditions.** To receive an interim payment rate, a nursing facility must comply with the requirements and is subject to the conditions in Section 16.140, items A to C.

The Department shall determine interim and settle-up operating cost payment rates for a newly constructed nursing facility, or one with an increase in licensed capacity of 50 percent or more according to Sections 12.020 and 12.030.

SECTION 12.020 **Interim operating cost payment rate.** Notwithstanding sections 8.000 through 11.000 that were effective until July 1, 1999 (or Section 8.010 that was effective until July 1, 2001), for the rate year or portion of an interim period beginning on or after July 1, 1987, the interim total operating cost payment rate must be determined according to Sections 1.000 to 15.000, except that:

A. The nursing facility must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in Section 13.000 to determine the anticipated standardized resident days for the reporting period.

B. The Department shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The Department shall use the anticipated resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

D. The annual adjustment factors determined in Section 10.010, must not be applied to the nursing facility's allowable historical per diems as provided in Sections 11.020 and 11.040.

E. The efficiency incentive in Section 11.040, items A or B, must not apply.

SECTION 12.030 **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for interim periods before July 1, 1987, is subject to the rule parts that were in effect during the interim period.

B. To determine the settle-up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in Section 9.020 must be used for the interim period.

(2) The Department shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The Department shall use the actual resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in Section 10.010 must not be applied to the nursing facility's allowable historical per diems.

(5) The efficiency incentive in Section 11.040, items A or B, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in Section 11.040, item A or B, applies.

D. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under Sections 6.000 to 16.090.

E. A newly-constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle-up total operating cost payment rate is determined under this subpart.

~~**SECTION 13.000 RESIDENT CLASSES AND CLASS WEIGHTS.**~~

~~SECTION 13.010 **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with Sections 15.000 to 15.060 (Resident Assessment Section).~~

~~A. A resident or applicant must be assessed as dependent in an activity of daily living according to the following table:~~

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2

~~Toileting 1~~

~~B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.~~

~~C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitems (1) or (2):~~

~~(1) the resident or applicant is assessed to require tube feeding; or~~

~~(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:~~

~~(a) oxygen and respiratory therapy;~~

~~(b) ostomy/catheter care;~~

~~(c) wound or decubitus care;~~

~~(d) skin care;~~

~~(e) intravenous therapy;~~

~~(f) drainage tubes;~~

~~(g) blood transfusions;~~

~~(h) hyperalimentation;~~

~~(i) symptom control for the terminally ill; or~~

~~(j) isolation precautions.~~

~~D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision,~~

~~Clinical Modification (ICD-9-CM).~~

~~(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);~~

~~(2) cerebrovascular disease (430-438 excluding 437);~~

~~(3) fracture of skull (800-804), excluding cases without intracranial injury;~~

~~(4) intercranial injury, excluding those with skull fracture (850-854);~~

~~(5) fracture of vertebral column with spinal cord injury (806);~~

~~(6) spinal cord injury without evidence of spinal bone injury (952);~~

~~(7) injury to nerve roots and spinal plexus (953); or~~

~~(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).~~

~~E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.~~

~~SECTION 13.020 **Resident classes.** The Department shall establish resident classes according to items A to K.~~

~~A. A resident must be assigned to class A if the resident is assessed as:~~

~~(1) Low ADL;~~

~~(2) not defined behavioral condition; and~~

~~(3) not defined special nursing.~~

~~B. A resident must be assigned to class B if the resident is assessed as:~~

~~(1) Low ADL;~~

~~(2) defined behavioral condition; and~~

~~(3) not defined special nursing.~~

~~C. A resident must be assigned to class C if the resident is assessed as:~~

~~(1) Low ADL; and~~

~~(2) defined special nursing.~~

~~D. A resident must be assigned to class D if the resident is assessed as:~~

~~(1) Medium ADL;~~

~~(2) not defined behavioral condition; and~~

~~(3) not defined special nursing.~~

~~E. A resident must be assigned to class E if the resident is assessed as:~~

~~(1) Medium ADL;~~

~~(2) defined behavioral condition; and~~

~~(3) not defined special nursing.~~

~~F. A resident must be assigned to class F if the resident is assessed as:~~

~~(1) Medium ADL; and~~

~~(2) defined special nursing.~~

~~G. A resident must be assigned to class G if the resident is assessed as:~~

~~(1) High ADL;~~

~~(2) scoring less than three on the eating ADL;~~

~~(3) not defined special nursing; and~~

~~(4) not defined behavioral condition.~~

~~H. A resident must be assigned to class H if the resident is assessed as:~~

~~(1) High ADL;~~

~~(2) scoring less than three on the eating ADL;~~

~~(3) defined behavioral condition; and~~

~~(4) not defined special nursing.~~

~~I. A resident must be assigned to class I if the resident is assessed as:~~

~~(1) High ADL;~~

~~(2) scoring three or four on the eating ADL;~~

~~(3) not defined special nursing; and~~

~~(4) not defined neuromuscular condition.~~

~~J. A resident must be assigned to class J if the resident is assessed as:~~

~~(1) High ADL;~~

~~(2) scoring three or four on the eating ADL;~~

~~(3) not defined special nursing; and~~

~~(4) defined neuromuscular condition or scoring three or four on behavior~~

~~K. A resident must be assigned to class K if the resident is assessed as:~~

~~(1) High ADL; and~~

~~(2) defined special nursing.~~

~~SECTION 13.030 **Class weights.** The Department will assign weights to each resident class according to items A to K.~~

~~A. Class A, 1.00;~~

~~B. Class B, 1.30;~~

~~C. Class C, 1.64;~~

~~D. Class D, 1.95;~~

~~E. Class E, 2.27;~~

~~F. Class F, 2.29;~~

~~G. Class G, 2.56;~~

~~H. Class H, 3.07;~~

~~I. Class I, 3.25;~~

~~J. Class J, 3.53;~~

~~K. Class K, 4.12.~~

SECTION 14.000 RESIDENT CLASSES, CLASS WEIGHTS AND RESIDENT ASSESSMENT SCHEDULES.

SECTION 14.010 **Resident classes.** Resident classifications are based on the Minimum Data Set (MDS), version 2.0 assessment instrument, or its successor, mandated by the Centers for Medicare & Medicaid Services. The Department of Health establishes resident classes according to the 34-group, Resource Utilization Group, version III (RUG-III) model. Resident classes are established based on the individual items on the MDS set and must be completed according to the facility manual for case mix classification issued by the Department of Health.

A. Each resident is classified based on the information from the MDS according to the general domains in subitems (1) to (7):

(1) extensive services when a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation when a resident requires physical, occupational, or speech therapy;

(3) special care when a resident has:

(a) cerebral palsy;

(b) quadriplegia;

(c) multiple sclerosis;

(d) pressure ulcers;

(e) ulcers;

(f) fever with vomiting, weight loss, pneumonia, or dehydration;

(g) surgical wounds with treatment;

(h) tube feeding and aphasia; or

(i) is receiving radiation therapy;

(4) clinically complex status when a resident has tube feeding, burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, dialysis, oxygen, transfusions, foot infections or lesions with treatment, heiplegia/hemiparesis, physician visits or order changes, or diabetes with injections and order changes;

(5) impaired cognition when a resident has poor cognitive performance;

(6) behavior problems when a resident exhibits wandering or socially inappropriate or disruptive behavior, has hallucinations or delusions, is physically or verbally abusive toward others, or resists care, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning when a resident has no special clinical conditions.

B. Detailed descriptions of each RUG are defined in the facility manual for case mix classification issued by the Department of Health. The 34 groups are:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;